Doctor's Name ____

Address ____

Phone ____

Date ____

Informed Consent for the recommendation or prescription for the use of:

Prescription medications
Over-the-counter drugs
Herbal remedies
Homeopathic remedies
Food supplements

Dr□____________________________
agent(s), herbal remedy(s), homeopathic remedy(s) or food supplement(s).

1. ____
2. ____
3. ____
4. ____

Dr. ______________________ explained to me the possible reactions or side effects I might experience while taking this/these substances. All questions I had concerning this/these substances were answered to my satisfaction. I understand that should I experience an unexpected reaction to this/these substances I am to contact Dr. ____________________________ immediately.

Signature: ____________________________
Patient

Signature: ____________________________
Doctor

Signature: ____________________________
Parent/Legal Guardian
(if patient is under 18)

Signature: ____________________________
Witness
(Professional Staff Member)

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